Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUMMIT REHAB CENTERS
2420 EAST RANDAL MILL ROAD
ARLINGTON TEXAS 76011

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-06-5636-01

MFDR Date Received

May 2, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 7/6/05 through 9/23/06: The claim is compensable, [sic] Included please find a benefit dispute agreement."

Amount in Dispute: $441.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier is currently reviewing this matter as the date of service 7/6/05 through 9/23/05 were previously denied based on compensability dispute. The parties signed an agreement on 2/16/06 agreeing that the claimant sustained a fractured right fibula. Thus, Carrier likely needs to re-process the bills for payment. Carrier will supplement this response as necessary."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2005	A4556	$16.00	$0.00
July 21, 2005	97124	$27.81	$0.00
July 22, 2005	97022	$18.35	$0.00
July 27, 2005	95851	$24.88	$0.00
August 26, 2005	99080-73	$15.00	$15.00
September 13, 2005	97110	$279.44	$268.48
September 23, 2005	95851 x 2 units	$60.11	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute resolution for which the dispute resolution request was filed on or after January 1, 2003.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional services provided between August 1, 2003 and March 1, 2008.
3. 28 Texas Administrative Code §129.5 sets out the Work Status Report guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 1, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 –Level II certified provider

   Explanation of benefits dated August 15, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 –Level II certified provider

   Explanation of benefits dated August 16, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 – Level II certified provider

   Explanation of benefits dated August 17, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 – Level II certified provider

   Explanation of benefits dated September 21, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 – Level II certified provider
   - 3 – This charge has been reimbursed according to the appropriate fee schedule or usual and customary value.
   - * – Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review

   Explanation of benefits dated October 6, 2005
   - 1 – This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice).
   - 2 – Level II certified provider

   Explanation of benefits dated October 24, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 – Level II certified provider
   - * – Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review

   Explanation of benefits dated October 28, 2005
   - 1 – This workers' compensation claim has been denied
   - 2 – Level II certified provider
   - * – Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review

Issues

1. Did the requestor submit an updated table of disputed services?
2. Does the dispute have unresolved Compensability, Extent of Injury or Liability (CEL) issues?
3. Did the requestor bill for unbundled codes?
4. Did the requestor submit documentation to support the billing of CPT code 97110 and 99080-73?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted an updated table on August 1, 2006, changing disputed date of service from 9/14/2005 to 9/13/2005. The disputed amount remained the same $441.59.

2. Per 28 Texas Administrative Code §133.307(e)(2)(D), "(e) Request (General). All provider and carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission. (Requests for medical dispute resolution on medical fee disputes involving an employee's request for reimbursement of medical expenses are governed by subsection (f) of this section). (2) Each copy of the request shall be legible, include only a single copy of each document, and shall include: (D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission."
   - Review of the Benefit Review Agreement, dated February 16, 2006 documents "The Claimant did sustain a fractured right fibular compensable injury on 6/27/05."
   - The requestor billed with primary diagnosis code 823.01 defined as "Closed fracture of upper end of fibular."
   - Therefore, the CEL issues are resolved and the dispute is eligible for a Medical Fee Dispute review. The disputed issues will be reviewed according to the applicable guidelines.
3. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exist for each disputed date of service. The following CCI edits were identified; however the procedure codes listed below are not in dispute
   - Date of service: July 6, 2005; disputed HCPCS code: A4556. The following procedure codes were billed: 95851, 96004, 97002, 97110, 97140, 99213, A4556, and G0283. Procedure Code A4556 is an item or service for which payment is bundled into payment for other physician services. Reimbursement is therefore not recommended for HCPCS code A4556.
   - Date of service: July 21, 2005; disputed CPT code: 97124. The following procedure codes were billed: 73600, 97113, 97124, 97140, and 99213. CCI Edit - Procedure 97140 and component procedure 97124 are unbundled. Reimbursement cannot be recommended for CPT code 97124.
   - Date of service: July 22, 2005; disputed CPT code 97022. CCI Edit - Procedure 97113 and component procedure 97022 are unbundled. The Standard Policy Statement reads "CPT Manual and CMS coding manual instructions". Reimbursement cannot be recommended for CPT code 97022.
   - Date of service: July 27, 2005; disputed CPT code 95851. CCI Edit - Procedure 99213 and component procedure 95851 are Unbundled. Reimbursement cannot be recommended for CPT code 95851.
   - Date of service: August 26, 2005; disputed CPT code 99080-73. No edit conflicts were identified. The disputed DWC73 will be reviewed according to the applicable fee guidelines.
   - Date of service: September 13, 2005; disputed CPT code 97110. No edit conflicts were identified. Procedure Code 97110 will therefore be reviewed according to the applicable fee guidelines.
   - Date of service: September 23; disputed CPT code 95851 x 2 units. CCI Edit - Procedure 99213 and component procedure 95851 are unbundled. A modifier is not allowed. Reimbursement cannot be recommended for CPT codes 95851 x 2 units.
4. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.
   - The requestor submitted an updated table changing the disputed date of service from September 14, 2005 to September 13, 2005.
   - The requestor submitted a copy of the CMS 1500 for date of service September 13, 2005, billing for CPT codes 99082 and 97110.
   - The requestor billed for 8 units of CPT code 97110. Review of the documentation submitted titled "S.O.A.P. Notes" documents 120 minutes of CPT code 97110, a total of 8 units/15 minute increments.
   - The Medicare fee schedule amount is $26.85 x 125% = $33.56/unit x 8 units = MAR $268.48. This amount is recommended.

5. Per 28 Texas Administrative Code §129.5 "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided." Review of the submitted documentation finds that:
   - Review of the DWC-73 meets the documentation requirements. Therefore, the requestor is entitled to reimbursement in the amount of $15.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $283.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $283.48 plus applicable accrued interest per 28 Texas Administrative Code use §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 10, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.